NISA
Neurology Institute
of San Antonio

Medical Questionnaire

Check boxes on all current and past conditions.

Patient Name:_____ DOB:_____
MONTH / DATE / YEAR

General
- ☐ Decreased appetite
- ☐ Excessive fatigue
- ☐ Fever
- ☐ Weight loss

Allergic/Immunologic
- ☐ Food allergies
- ☐ Inhalant allergies
- ☐ Drug allergies

Cardiovascular
- ☐ Chest pain/angina

Last EKG Date:_____
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular pulse
- ☐ Leg pain while walking
- ☐ Pacemaker
- ☐ Swollen hands/feet

Ear, Nose, Throat, Mouth
- ☐ Wearing hearing aids

Last Exam Date:_____
- ☐ Congestion
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Inability to smell
- ☐ Mouth sores
- ☐ Nose bleed
- ☐ Sinus
- ☐ Sinus headaches
- ☐ Sore throat

Endocrine
- ☐ Diabetes
- ☐ Hormone problem
- ☐ Increased appetite
- ☐ Increased thirst/urination
- ☐ Thyroid disease

Eyes
- ☐ Wearing glasses

Last Exam Date:_____
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Infections
- ☐ Injuries

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in vomit
- ☐ Change in bowel habits
- ☐ Colon cancer
- ☐ Diverticulitis
- ☐ Gallbladder problems
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ IBS/Colitis
- ☐ Jaundice
- ☐ Liver disease
- ☐ Nausea/vomiting
- ☐ Persistent
- ☐ Ulcer/gastritis

Genitourinary
- ☐ Breast pain
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Loss of bladder control
- ☐ Menstrual flow irregular
- ☐ Menopause
- ☐ Painful urination
- ☐ Prostate problems
- ☐ Sexually transmitted disease
- ☐ Urinary tract infection
- ☐ Uterine/cervical cancer

Birth control method:_____
Last PAP Date:_____
Last Mammogram Date:_____

Hematology/Lymphatic
- ☐ Anemia
- ☐ Bleeding tendencies
- ☐ Phlebitis
- ☐ Persistent swollen glands or lymph nodes
- ☐ Blood transfusion

Date:_____

Integumentary
- ☐ Skin disease

Type:_____
- ☐ Rash

Location:_____

Lifestyle
- ☐ Add salt to your food
- ☐ Advanced Directive Power of Attorney
- ☐ Eat out frequently
- ☐ Eat salty foods
- ☐ Exercise regularly
- ☐ Living will
- ☐ Drink alcoholic drinks

Frequency:_____
- ☐ Drink coffee, tea, soda

Frequency:_____
- ☐ Smoke cigarettes

Frequency:_____

Musculoskeletal
- ☐ Back/neck pain
- ☐ Arm/leg pain
- ☐ Joint pain/swelling
- ☐ Arthritis
- ☐ Broken bones
- ☐ Osteoporosis

Neurological
- ☐ Concentration problems
- ☐ Difficulty with speech
- ☐ Disorientation/confused
- ☐ Double/blurred visions
- ☐ Facial weakness
- ☐ Fainting/blackout spells
- ☐ Headaches
- ☐ Memory problems
- ☐ Muscle weakness
- ☐ Numbness/tingling
- ☐ Seizures
- ☐ Strokes
- ☐ Tremors/hand shaking

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Mental illness
- ☐ Sleeping difficulty

Respiratory
- ☐ Asthma
- ☐ Bloody sputum
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Lung cancer
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ TB

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Medical Questionnaire *Continued*

Patient Name:_____ DOB:_____
MONTH / DATE / YEAR

Reason for Visit:_____

Surgeries	Year	Complication

Hospitalizations	Year	Complication

Has the patient had past complications with Anesthesia? ☐ Yes ☐ No

CT/MRI Studies	Location	Date	Doctor Ordering

Family Medical History *Check boxes on all conditions that apply, indicate the affected relative(s).*

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Meniere's disease
- ☐ Mental illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid problem

Relative(s):

_____

_____

_____

_____